

APPENDIX 4b  
BILLING EXAMPLE

TARGETED OUTREACH / COMPREHENSIVE SCREEN WITH IMMUNIZATION

CLAIM SORT INDICATOR "P"

RECEIVED BY THE FISCAL AGENT ON OR AFTER 2/15/95

HEALTHCHECK NURSING AGENCY PROVIDER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #) <b>P</b> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>				1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>1234567890</b>			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Recipient, Im A</b>				3. PATIENT'S BIRTH DATE MM DD YY <b>MM DD YY</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) <b>609 Willow St.</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY <b>Anytown</b>		STATE <b>WI</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY	
ZIP CODE <b>55555</b>		TELEPHONE (Include Area Code) <b>(XXX) XXX-XXXX</b>		10. IS PATIENT'S CONDITION RELATED TO: Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-Y</b>				11. INSURED'S POLICY GROUP OR FECA NUMBER		TELEPHONE (INCLUDE AREA CODE) <b>( )</b>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> SEX	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> SEX				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____			
14. DATE OF CURRENT: MM DD YY <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN			
19. RESERVED FOR LOCAL USE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <b>V70 0</b>				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
2. _____				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES			
3. _____				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
4. _____				23. PRIOR AUTHORIZATION NUMBER			
24. A DATE(S) OF SERVICE To From MM DD YY MM DD YY		B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSDT Family Plan	
I EMG		J COB		K RESERVED FOR LOCAL USE			
1 02 01 95 3 1 W7012 1 XX XX 1							
2 02 01 95 3 1 99392 HC 1 XX XX 1							
3 02 01 95 3 1 W7018 1 XX XX 1							
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. <b>1234JD</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>XXXX XX</b>	
29. AMOUNT PAID \$		30. BALANCE DUE \$ <b>XXXX XX</b>		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>I.M. Authorized</b> SIGNED _____ DATE <b>MM/DD/YY</b>		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>I. M. Billing</b> <b>1 W. Williams</b> <b>Anytown, WI 55555</b> PIN# _____ GRP# <b>87654321</b>							